Wyoming Department of Health

Abortion Certification Form

Physician Name _____ **Physician NPI/ Provider Number** _____

Physician Address _____
Street Address City State Zip Code

Member Name _____ **Member ID** _____

Member Address _____
Street Address City State Zip Code

I, (Physician) _____, certify that:

☐ My patient suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition cause by or arising from the pregnancy itself, that would place her in danger unless an abortion is performed; or

☐ This pregnancy is a result of sexual assault as defined in W.S. 6-2-301 which was reported to a law enforcement agency within five (5) days after the assault or within five (5) days after the time the victim was capable of reporting the assault; or

☐ This pregnancy is the result of a sexual assault as defined in the Wyoming Statute W.S. 6-2-301 and the member was unable, for physical or psychological reasons, to comply with reporting requirements; or

☐ This pregnancy is the result of incest.

Physician Signature _____ **Date** _____
mm/dd/yyyy

Physician Name (Printed) _____

WYBMS-Abortion Certificate Form